

§ 156.50

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in §155.20 of this subtitle.

Cost-sharing has the meaning given to the term in §155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in §155.20 of this subtitle.

Group health plan has the meaning given to the term in §144.103 of this subtitle.

Health insurance coverage has the meaning given to the term in §144.103 of this subtitle.

Health insurance issuer or issuer has the meaning given to the term in §144.103 of this subtitle.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(1) of the Affordable Care Act of plan coverage.

Plan year has the meaning given to the term in §155.20 of this subchapter.

Qualified employer has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan issuer has the meaning given to the term in §155.20 of this subchapter.

Qualified individual has the meaning given to the term in §155.20 of this subchapter.

[77 FR 18468, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

§ 156.50 Financial support.

(a) *Definitions.* The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in §155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in §155.1065 of this subtitle), or

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other issuers identified by an Exchange.

(b) *Requirement for Exchanges user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by the Federally-facilitated Exchange under 31 U.S.C. 9701 or a State-based Exchange under §155.160 of this subchapter.

Subpart B—Standards for Essential Health Benefits, Actuarial Value, and Cost Sharing

SOURCE: 77 FR 42670, July 20, 2012, unless otherwise noted.

§ 156.120 Collection of data from certain issuers to define essential health benefits.

(a) *Definitions.* The following definitions apply to this section, unless the context indicates otherwise:

Health benefits means benefits for medical care, as defined at §144.103 of this chapter, which may be delivered through the purchase of insurance or otherwise.

Health insurance product has the meaning given to the term in §159.110 of this chapter.

Health plan has the meaning given to the term, “Portal Plan” in §159.110 of this chapter.

Small group market has the meaning given to the term in §155.20 of this chapter.

State has the meaning given to the term in §155.20 of this chapter.

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitations include only quantitative treatment limitations. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.

(b) *Required information.* The issuers described in paragraph (c) of this section must provide the following information for the health plans described in paragraph (d) of this section in accordance with the standards in paragraph (e) of this section:

(1) Administrative data necessary to identify the health plan;

(2) Data and descriptive information for each plan on the following items:

- (i) All health benefits in the plan;
- (ii) Treatment limitations;
- (iii) Drug coverage; and
- (iv) Enrollment;

(c) *Issuers required to report.* The issuers that offer the three largest health insurance products by enrollment, as of March 31, 2012 (enrollment is determined by HHS based on data submitted in accordance with part 159 of this title) in each state's small group market must provide the information in paragraph (b) of this section.

(d) *Plans affected.* The issuers described in paragraph (c) of this section must provide the information described in paragraph (b) of this section for the health plan with the highest enrollment (as determined by the issuer) within the products described in paragraph (c) of this section.

(e) *Reporting requirement.* To ensure consistency in reporting, an issuer described in paragraph (c) of this section must submit, in a form and manner to be determined by HHS, the information described in paragraph (b) of this section to HHS no later than September 4, 2012.

Subpart C—Qualified Health Plan Minimum Certification Standards

SOURCE: 77 FR 18469, Mar. 27, 2012, unless otherwise noted.

§ 156.200 QHP issuer participation standards.

(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) *QHP issuer requirement.* A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

(6) Pay any applicable user fees assessed under § 156.50; and

(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.

(c) *Offering requirements.* A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and,

(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.

(d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.

(e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

§ 156.210 QHP rate and benefit information.

(a) *General rate requirement.* A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.